Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION N	UMBEK:	A. BUILDING:		COMP	PLETED
		HAL060049		B. WING		04/0	01/2022
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PPOOK	DALE CARRIAGE CLU	ID DDOVIDENCE	5816 OLD	PROVIDEN	CE ROAD		
BROOKL	DALE CARRIAGE CLO	DB PROVIDENCE	CHARLO	TTE, NC 282	226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 000	Initial Comments			D 000			
D 161	Mecklenburg Count Services conducted complaint investiga 04/01/22. The com- initiated by the Mec- of Social Services of 10A NCAC 13F .05 For LHPS Tasks 10A NCAC 13F .05 Licensed Health Pr	04(a) Competency \ 04 Competency Val ofessional Support	ocial and ough was epartment  Validation  idation For Task	D 161			
	(a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.						
	reviews, the facility sampled staff (Staff validated for Licens Support (LHPS) tas changes, feeding to administration throughnon-ambulatory res	et as evidenced by: ions, interviews and failed to ensure 2 of A and C) were comed Health Professionsks related to clean electriques, medications and ambulation at require physical and trequire physical and complete ions.	f 3 npetency onal dressing on ers of ion using				
	The findings are:						
	1. Review of Staff A	A's, medication aide	(MA),				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		HAL060049	B. WING		04/0	1/2022
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BROOKE	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN			
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D 161	Continued From pa	ige 1	D 161			
	a LHPS validation i					
	revealed: -She was hired by a December of 2021 January 2022The Registered Nu agency completed a her training upon hit-Her responsibilities administer medicat care aides (PCAs) at the residentsShe administered injection, applied Thresidents, clean dresidents, clean dresidents, clean dresidents.	a local staffing agency in and started at the facility in urse (RN) at the staffing an LHPS check off as part of				
	stand or hoyer lift, a wheelchairs who we independently.  -The facility nurse of demonstration of the required to perform.  -She did not know training at the facility any training while we Director (HWD) on Refer to interview we defer to inte	and assisted residents in ere not able to ambulate did not require a return he LHPS tasks she would be how was responsible for ty since she did not receive				
	Refer to interview wagency on 04/01/22	vith the RN at the staffing 2 at 2:00pm.				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)			X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 161	2. Review of Staff C personnel record re-Staff C was hired c-There was no doct a LHPS validation in Interview with Staff revealed: -She worked as a N staffing agency since-Her responsibilities administer medicatic care aides (PCAs) the residentsShe administered injection, applied Thresidents, clean dreassisted with transfistand or hoyer lift, a wheelchairs who we independentlyThe facility nurse of demonstration of the required to perform -She did not remember checked her off for went to the facilityShe did not know we training at the facility any training while we Observation of Staff revealed she provious resident in the dining meal.	with the Administrator on om.  C's, medication aide (MA), evealed: on 02/03/22. Unmentation Staff C completed in the personnel records.  C on 04/01/2022 at 10:00am  MA in the facility from a local ce February 2022. So at the facility were to ions and assist the personal with the personal care tasks of insulin through subcutaneous ED hose, assisted with feeding essing changes if needed, ers of residents using a sit to and assisted residents in ere not able to ambulate  Ilid not require a return e LHPS tasks she would be aber if the staffing agency RN any LHPS tasks before she who was responsible for the staff of the staff	D 161			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 3 of 86

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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D 161	Continued From pa	ge 3	D 161			
	12:40pm.					
	Refer to interview v 11:45am.	vith the HWC on 04/01/22 at				
	Refer to interview w 04/01/22 at 2:00pm	vith the staffing agency RN on				
	Refer to interview with the Administrator on 04/01/2022 at 3:39pm.					
	revealed: -She was responsith had the required docare to the resident -She did not know a RN educator to per off for LHPS compostaff before they prostaffing agency profinterview with the Frevealed: -The HWD schedul Nurse (RN) to composite the did not know the standard of the standard of the HWD schedul Nurse (RN) to composite the standard of the schedul Nurse (RN) to composite the standard of the schedul Nurse (RN) to composite the schedul Nurse (RN) to comp	she should alert the facility's form a facility specific check etency validation for agency ovided care to the residents. raining and check offs the vided.  IWC on 04/01/22 at 11:45am ed the facility's Registered e in and complete the LHPS reviews.  the skin assessments and				
	on Residents #1 and Interview with the sat 2:00pm revealed -She completed the medication aides be facilityShe also provided staff as part of the interview with the same control of the	taffing agency RN on 04/01/22				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 4 of 86

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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BROOKE	DALE CARRIAGE CLI	IR PROVIDENCE	PROVIDEN TTE, NC 282			
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D 161	Continued From pa	nge 4	D 161			
	for the staff as part -She had not been documentation of the Interview with the A 3:39pm revealed: -She was not award validation requirem for residentsThe facility's Regis was responsible to facility specific train -It was the responsing nurse educator of reacility specific train -She did not know walidation for staff services.	of their training. asked to provide the raining to the facility. Administrator on 04/01/2022 at e of the LHPS competency ents for staff performing care stered Nurse (RN) Educator check off all agency staff on ning requirements. ibility of the HWD to inform the new employees requiring				
D 269	Supervision  10A NCAC 13F .09 Supervision (a) Adult care home care to residents and plans and attend to needs residents mathemselves.  This Rule is not mathematically and the supervision (a) Adult care home care to residents and attend to needs residents mathematically and the supervision (b) The supervision (c) The supervis		D 269			
	reviews, the facility	s, observations and record failed to ensure staff provided stance to 2 of 3 sampled				

Division of Health Service Regulation STATE FORM

6899 OP9N11 If continuation sheet 5 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DA' COI			
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OLI	DDRESS, CITY, S D PROVIDENC TTE, NC 282	CE ROAD		
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D 269	residents (Resident resident with diabet the heels of both fe protective booties, wounds and not to during ambulation with the Home Health N physician and not a and nail care on bowith recurrent pressifeet, orders to place obtained 3 addition buttocks, and order wounds (#1).  The findings are:  1. Review of Resided -Diagnoses included diabetes, left sided -He was documente and non-ambulator -The current level of Special Care Unit (Special Care Unit (PCP) progress not there was an order and treat the resident heel twice a week.  Review of Resident (HHN) documentation an order for a left for the staff daily when	is #3 and #1) including one ic pressure ulcer wounds on et and orders to place off load pressure to the drag his feet along the floor were followed as ordered by urse (HHN) and wound care ttending to multiple skin tears th feet (#3), and a resident sure ulcers on the heel of both is protective booties, who all wounds on the sacrum and is to off load pressure to the ent #3's current FL2 dated d vascular dementia, Type II hemiplegia and glaucoma. Type II hemip				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	IB PROVIDENCE	PROVIDEN			
	ı	CHARLO	TTE, NC 282			
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D 269	Continued From pa	ge 6	D 269			
	dated 03/03/22 revelopments to protect the dragged on the ground	ealed an order for foam foot ne wound when his foot und.				
	01/31/22 revealed: -Resident #3 require	#3's current Care Plan dated ed staff assistance for all ning needs, and for weekly				
	<ul><li>-He required staff to assist with bathroom tasks related to his inability to stand.</li><li>-He ambulated in a wheelchair with the</li></ul>					
		o the dining area and s, and transferred with the aid n assistance.				
	Review of the facilty's clinical guidelines regarding skin breakdown dated September 2018 revealed: -Community associates should report skin concerns to the Health and Wellness Director (HWD).					
	completed upon a c -Skin observation m frequently based or	vation Form should be change of condition. hay be completed more the individual resident's				
	-Management in the breakdown includes for mattresses, gel	e's clinical judgement. e community of skin s high density foam overlays cushion for the wheelchair nt's heels off the bed.				
	-Encourage position -Manage incontiner barrier ointment to l	n change. nce as needed, applying a				
	-Document on the ( with a separate she	zinc and vitamin C intake.  Dpen Area flowsheet weekly et for each open area, the Executive Director and				
	the HWDUpdate the Person					

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 7 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:  (X3) DATE COMP			E SURVEY PLETED	
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	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, ST PROVIDENC TTE, NC 2822	E ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 269	Assessment/Perso-Provide in-service skin breakdown.  Review of Resident Observation Form on The form was community Wellness Coordination - Skin was document and flakiness", with seriction and shear a problem.  A Braden Scale was developing pressurance - Resident #3's Braden Scale so prevention strategies. No prevention strategie	nal Service Plan. to associates on preventing  at #3's most recent Skin dated 02/17/22 revealed: upleted by the Health and tor (HWC). Inted as "excessive dryness an open area on the left heel. Ing were documented as "not as used to predict the risk of e sores in a resident. Iden Scale was 14, indicating a eveloping pressure sores ore of 16 or less required es. tegies were listed. wsheet was to be completed oted on the left heel.  If Resident #3's Open Area ands to the right and left heel prior to exit.  Assignment Plans from				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 8 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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D 269	required 2 person a lift.  -There was no entry his right and left foot to both feet when owhen in the wheelcheet when in a dependent when in the wheelcheair.  a. Observation on Continuous of the wheelchair.  a. Observation on Continuous of the wheelchair was postaff to his room be resting on the floor. He had yellow non no observable dressendent #3 was postaff to his room be staff propelled him hall with his feet draws was as wheelchair.  Observation of Ressendent was postaff to his room.  -The resident was postaff to his room.  -The resident had y feet and his feet draws propelled in his hall.  -In his bedroom, on were 2 purple foam.	regarding pressure uport, foam booties to be a ut of bed, to elevate his hair, provide a pillow upondent position and his ng the floor when push 13/29/22 at 9:25am, at 10pm revealed: itting in a highback who garea after breakfast. Indent and his feet we skid socks on both feetsings.  Topelled in his wheeler fore lunch.  The wheelchair down agging on the floor.  The dining room for lust wheelchair.  Skid socks on both feets wheelchair.  The dining room for lust wheelchair wheelchair wheelchair by staff down at chair at the foot of the later the foot of the later at the late	alcers on applied s legs ander his is feet hed in eelchair re et and mair by which at et and et and et and et et et and et et et and et et et and et	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 9 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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D 269	the bed with the assand 2 staff.  -Removing the sociboth feet from the hard of the area.  -The dressings were staff since there we areas.  -When the resident was a large bowel reaked onto his skin.  -The buttocks and streddened and 3 adia a dime, were obserthere was no evid applied to the area.  Review of Resident dated 02/18/22 three.  -The HHN Clinical I start of care for the assessment of it was an unstageal was covered extense.  -HH treated the left 03/11/22, when and case.  -The left heel press 03/11/22.  Telephone interview 03/30/22 at 11:20ar.  -The start of care we two days a week.  -The pressure ulcer.	sistance of a sit to si ks, there were dress heel to above the and re wrapped with gaus rent wrap, to secure re unable to be remove ere no supplies to rec surrounding area wa ditional open areas, rved. ence of a barrier cre t #3's HHN documer ough 03/11/22 reveal Manager dated the r left heel wound as 0 of the left heel wound ble pressure ulcer (the sively with dead tissue theel pressure ulcer of the agency took over the country of the country with the previous heel with the previous heel with the previous here.	ings on kle. Ze and them to oved by dress the d, there which was the size of earn of the wound well. It was that he wound well. Until ter the geable on the seen seen seen seen seen seen seen se	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 10 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN TE, NC 282			
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D 269	needed to be remo -On 02/23/22 the w -A left heel protector applied by the staff off load the pressur wheelchairAfter 3 weeks the wand it was recomm Wellness Coordina wound clinic was reShe did not have a #3 was seen at the -On two occasions provide care, Resid wheelchair with no or pillow under his to the wounds.  Review of Resident dated 03/04/22 and -On 03/04/22, the fi aide (MA) documer #3 on 03/03/22, dre ordered foam foot to when his foot dragg wheelchair ambulat -On 03/09/22, it wa left heel wound was infected, with black -The heel was not was reported to the Coordinator (HWC) -The HWC reported care of the woundThe skin on the rig down also and requ -This was also reported Review of Resident	ved to heal). ound had no sign of infection. or was ordered and was to be and a pillow under his feet, to re when sitting in the  wound was still unstageable ended to the Health and tor (HWC) that a visit to the equired. any documentation Resident wound clinic at that time. when she visited the facility to lent #3 was sitting in his protective booties on his feet feet to reduce the pressure on  at #3's electronic progress note 1 03/09/22 revealed: first shift agency medication anted the HHN visited Resident tessed the left heel wound, and protect the wound doed on the ground (during tion). It was documented Resident #3's as bleeding and appeared ened tissue present. It was present. It was taking and to the MA that HH was taking and the back heel was breaking uired attention.	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 11 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
		A. BOILDING.			
	HAL060049	B. WING		04/0	01/2022
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BROOKDALE CARRIAGE CL	IIR PROVIDENCE	PROVIDENC TTE, NC 282			
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wound measurement 8.0cm Width and 0.  The left heel wour pressure ulcer and assessment to debe assessment for effective and some drainage and to keep while out of bed.  On 03/21/22, the left were 13.5cm L x 9 redness, serosang mixed with blood) and a serosanguinous drain bold letters and were strict instruction heels when transposed when transposed at the pressure ulcer on the assessment to detect the substitution of the woulf and protein until the protein until th	e on 03/17/22 the left heel ents were 14.0cm Length x form Depth. In a was an unstageable required wound clinic oride (remove the dead tissue). It is a stage 2 pressure ulcer, (a med wound with no dead tissue exposed), with redness and a schar, and required fective treatment and healing. Und measurements were 2.0cm th x 0.1cm depth, with redness exposed. It is a stage 2 diabetic the right and left heel. It is wound measurements were 2.0cm th x 0.1cm depth, with redness exposed in the foam booties on both feet were elevated when the foam booties on both feet left heel wound measurements were 2.5cm depth and some pain. Und measurements were 2.5cm depth and some pain. Und measurements were 2.5cm depth and left heel even to not drag the resident's corting.  It #3's wound clinic summary the right and left heel. It is debrided (dead tissue and noved) during the visit with the				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 12 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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D 269	plasma) drainage.  -The measurement L, 1cm W and 0.1c  -The fat layer benear a vaseline gauze draining interest and reported (03/04/22).  -Her next shift assigned and reported (03/04/22).  -Her next shift assigned and responded that the sunday and had are some and reported to the regarding Resident responded that the wound now. The state and requested pain -His feet were drag propelled in the whole	is of the total wound in D. ath the skin was expressing applied. also debrided during the wound exposed, to necessary. To of the left heel was at the wounds were to clear a factor of the left heel was at the wounds on his right and were to a different wounds on his right and the wounds on his right and the wounds on his right and the wound to the HV grament was the follow at the wound to the HV grament was the follow at the wound with the wound to the HV grament was the follow at the wound with the wounds and the wounds and the wounds are t	osed with the visit and 6.5cm L, eanse and ecure rear foam on and left size ress VC wing was ow thick asfers on 6.5e HWC e of the de any e wound esident. when	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 13 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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D 269	restraint and needed were not appliedHome Health start weeks ago when it -The foam booties his room were never she would start her.  Telephone interview HHN on 03/30/22 arguerent to a stage 2 pressure recommended seen at the wound woundsShe implemented clinic, documented informed the MA or the resident's heels and foam booties with times to protect his recommended should be seen at the and reinforced the booties and keeping-She had observed facility, the resident feet were on the flour line and genital areaShe assessed the additional skin breat not open on 03/28/2 resident.  Telephone interview	ed a physician's order, so the ed treating the wound about was quarter size. which were ordered and left er on Resident #3's feet whe shift. She had to apply then w with Resident #3's second t 9:51am revealed: HN assessed Resident #3's eel wound. unstageable, the right heel w ulcer. d to the HWC the resident b clinic for debridement of the the wound orders from the in the progress note and the floor and the HWC that were not to touch the floor were to be on his feet at all heels. d to the HWC that Resident he wound clinic a second tir necessity of wearing the foa g his feet off the floor. at times when she visited th 's booties were not on and h	3 in n n n s as e #3 ne, m ne nis 3 s ee			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		HAL060049	B. WING	<u></u>	04/0	01/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDENO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE PROVIDER OF THE APPLICATION	OULD BE	(X5) COMPLETE DATE
D 269	revealed: -She had ordered had resident #3's wourd change #3's wounds were reshe had not been open areas on the reaction of the informed by the factorial areas on Resident: -The facility had no mattress or wheeld interview with Resident on 03/30/22 at 10:3-She had consulted treatment for Resident in the wound resident's legs whe apply santyl daily (abreak up and remorpadding the heels are and reducing the propillow under his feed in the was in the whand/or not applying protection, this wouthe wounds.  Interview with a first aide (PCA) on 03/2-Resident #3 was to transfer from the best and reducing the propillow under his feed in the wounds.	HHN to evaluate and treat and son 02/17/22.  Irmed by the HWC that the lee HH agencies since Resident not healing.  Informed of any additional residents buttocks or genital hHN and herself to be ility staff of any new open #3.  It requested an order for a gel hair pad for Resident #3.  Ident #3's wound clinic nurse for more and the second revealed:  It with the physician providing	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 15 of 86

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL060049	B. WING		04/0	1/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKDALE CARRIAGE CLU	IR PROVIDENCE	PROVIDENO TTE, NC 282			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
protective foam bood pillow under his feet his feet.  -He had not been the working with the residents and it would go to the MA.  Interview with a sect at 10:05am revealed.  -This was her first described assistance with ambients and the residents need assistance with ambients.  -She was given repewhat residents need assistance with ambients.  -She would go to the information or assistance with the against and the residents.  -She would go to the information or assistance with the against and the residents.  -She was not aware place booties on Resident to off load powheelchair.  -She did not see the elevation of legs wheelcthoric medication (eMARs).  Review of Resident revealed:  -There was no entry	ed it to the HWC. e resident had to wear oties when out of bed or a t to off load the pressure on ained by the facility before sidents. other facilities and knew how s. ment sheets available in the f he had any questions he cond agency PCA on 04/01/22 d: lay at the facility. ort by the previous shift for ded personal care and bulation. ed any information from e personal care needs of the e MA if she needed additional	D 269			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 16 of 86 0P9N11

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		HAL060049	B. WING		04/0	01/2022
	PROVIDER OR SUPPLIER	5816 OLI	DDRESS, CITY, S	STATE, ZIP CODE CE ROAD	•	
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE CHARLO	TTE, NC 282	226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 269	wheelchairThere was no entry pressure on the wo resident's feet, whe Interview with the H and 04/01/22 at 11: -She was responsite physicians and enterview of the eMAR personal care issue with the physicians Care Unit (SCU)She was first awar wound last month woundHHN started care from and the wound was the wound bedAfter several week she requested a necaseThe second HHN street and the wound was the wound bedIt was the responsite Wellness Director (assessment when the condition and comp documentation week the resident's quarter professional Supportional Supportiona	y to elevate legs or reduce unds with a pillow under the in they were not elevated.  IWC on 03/30/22 at 3:55pm 45am revealed: Dele for receiving orders from ering orders on the eMARs, for accuracy of orders, and referral and follow up for the residents in the Special e of Resident #3's left heel when a PCA reported it to her. For the wound on 02/18/22, and unstageable due to Eschar in the sit was still unstageable, so we agency to take over the started care on 03/17/22 and bund clinic consult. Sibility of the Health and HWD) to complete a skin there was a change in the better the open wounds skly.  The skin assessment, open the skin assessment, open the skin assessment, open the skin and updated LHPS was	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 17 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED
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	HAL060049			04/0	1/2022
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S PROVIDEN	STATE, ZIP CODE		
BROOKDALE CARRIAGE CLUE	3 PROVIDENCE	TTE, NC 282			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
on each floor and deneeds for grooming, ambulation and feeding ambulation and feeding staff were supposed sheets to become fair resident.  -Agency staff were ding assignment binder for resident and to go to additional information. She did not know whom the assignment should be pressure and elevation wheelchair was not in assignment sheets for the also thought the included on the eMAI responsibility of the Accompleted.  -She had been told be foot rests were a restreason she had kept bound residents.  -She had not observe booties and a pillow the feet while she was in the HNN during starent wheelchair was not accompleter for the wound.  The facility was not accompleted with the HNN revealed:	or each week. Int sheets listed the residents acribed their personal care dressing, toileting, transfers, ing assistance. Ind to review the assignment miliar with the care of each directed to the staff or information on their of the MA or nurse for in if needed. In generated the information theets and why Resident #3's be applied, pillow to offload on of legs when sitting in the included in the weekly or the staff. It is ese interventions were the was to ensure the tasks were was to ensure the tasks were the was the off all wheelchair traint and that was the off all wheelchair the building. The building was the building of the building of the treatment and the care. In able to provide any wound was to overseeing the SCU of the scale of the scale of the SCU of the scale of the	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 18 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IR PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDEN			
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D 269	-Since they were 2 half her week in ear There was a HWC she relied on them operations of their reshe was not award 02/17/22 completed -Resident #3's presat that time by the Frecorded with aggretion the diet and a zintwould have been to follow up with the regarding wound hearing wound hear to follow up with the regarding wound hear to make the wincluded an assess healed.  -There were no opecompleted by her or the nursing staff wound was not hear right heel had been to ontinued skilled nupressure ulcers.  -The staff was awar pressure on the hear all agency staff on the get them to followed the was and ensure Reside pillow when he was the orders were in MA to complete the	different buildings, she ch building. in each of the building to handle the day to de respective buildings. of the skin assessme d by the HWC. sure ulcers were being HN and should have essive interventions list a especially with a dial quested an increase of the responsibility of the ephysician for interver ealing y policy that skin asses should have a follow up eekly by the HWC that ment of the wound un en wound flow sheets or the HWC on Resider vas concerned Reside aling and another wound observed. ange in HH agencies a ursing services for the first shift and it was a so w the HHN orders. It to apply the foam bo on #3's feet were propp on the wheelchair. In the eMAR, so it fell o	gs and ay ent on g treated been sted. petic, protein the HWC ontions ssments p flow the till that #3's and on the ener was struggle poties ped on a in the	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 19 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENGE ITE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
D 269	was no additional d notes, no entries or records (eMARs), or regarding the reside any care provided to pressure ulcers by a Interview with the A 3:39pm revealed: -She knew Resident was being treated be- -She did not know sorders of the HHN a b. Observation of R 3:30pm revealed: -The resident had be his wheelchair by start - -The toenails on bood discolored with dries areas near the cution -On the second toe yellow, tough mater reaching over to the -On the third, fourth there was a smaller tough material arous - -The toenails on the of the left foot were trimmed. Review of Resident dated 02/18/22 reversible to the right and left to	ocumentation in the of the electronic median personal care recordent's skin status, would the facility staff.  It was the facility staff.  It	cation ords unds or etic ords unds or etic ords unds or etic ords and ords ords ords ords ords ords ords ord	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 20 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OLI	DRESS, CITY, S'D PROVIDENC TTE, NC 282	CE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 269	Continued From pa	ge 20	D 269			
	03/17/22 and 03/21	nd HHN progress notes dated /22 revealed no ne condition of the toes and				
	-She was not aware abrasions, toenail on on the toes of the ri toenails needing to -She relied on the s	e of Resident #3's skin liscoloration and peeling skin ight and left foot, and the be trimmed. staff to inform her of any skin schedule an appointment on				
	revealed: -She completed Re on 02/17/22She documented h-She did not observe buildup around the focusing on his prescribed expected the inform her of any start providing personal lef she had been aw toes and toenails sleep.	personal care aides (PCAs) to kin breakdown when they were				
	revealed: -It was the respons skin assessments of Care Unit (SCU)She was not aware breakdown on the t and the yellowing to	o on 03/30/22 at 12:40pm ibility of the HWC to perform of the residents in the Special e of Resident #3's skin oes of his his right and left foot penails with thick crusting on ral toes on both feet, and	t			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 21 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 269	toenails needing to -The PCAs or MAs condition to the HW appointment should -The staff do not pr residents.  Interview with the A 3:39pm revealed: -She relied on the r clinical needs of the -She was not aware #3's toe nails and s -The HWD was res the SCU and could  Review of Resident was no additional d notes, no entries or records (eMARs), or regarding the reside toenails by the facil  Attempted telephor 04/01/22 at 10:20ar  Attempted telephor responsible family r 11:55am was unsue  Based on observati reviews it was dete interviewable.  Refer to interview w 3:55pm and 04/01/3	trimmed. should have reported this /C or herself and a podiatry have been made. ovide nail care to the dministrator on 04/01/22 at hursing staff to manage the ersidents. The of the condition of Resident kin tears on his toes. ponsible for the oversight of delegate tasks to the HWC. It #3's record revealed there ocumentation in the progress in the electronic medication or personal care records ent's skin status on his feet or ity staff.  The interview with the HWD on mass unsuccessful.  The interview with Resident #3's member on 03/30/22 at coessful.  The interviews, and record remined Resident #1 was not with the HWC on 03/30/22 at 22 at 11:44am.  The interview on 04/01/22 at 11:44am.	D 269			

6899

Division of Health Service Regulation STATE FORM

0P9N11 If continuation sheet 22 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/0	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDENCE TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 269	Refer to interview of Administrator.  2. Review of Reside 07/16/21 revealed of unspecified demention Review of Residention 12/30/21 revealed: -She had stage 2 put that were being treathealth agencyShe was encourage in bed and to wear she was incontineShe was incontineShe was incontineShe used a wheeled staff escort to and full staff	ent #1's current FL2 dated diagnoses included tia without behaviors.  If #1's current Care Plan dated ressure ulcers to her heels ated by the facility's home led to elevate her heels while her foam cushion booties. In the foam cushion booties of dementia and required from activities. It is of dementia and required from activities of daily on-verbal and staff had to so the foam obtained. In home health services, but a lis being obtained.	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 23 of 86

A. BUILDING:	
HAL060049 B. WING	04/01/2022
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  5816 OLD PROVIDENCE ROAD  CHARLOTTE, NC 28226	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	) BE COMPLETE
D 269  Continued From page 23  Hospice consult initiatedOn 01/05/22, the resident was admitted to Hospice due to an overall decline in status, not eating, and to monitor heel wounds.  Review of Resident #1's Licensed Health Professional Support (LHPS) dated 02/02/22 revealed: -She had been transferred from home health services to Hospice care on 01/05/22 for continued wound care to bilateral heel pressure ulcers, decline, and weight lossLHPS tasks were transfers and wound care.  Review of Resident #1's current Skin Observation form dated 02/03/22 revealed: -Her skin was documented as intact, with no open areasShe was chairfast and completely immobileShe had no apparent problem with friction and shearHer Braden Scale for Predicting Pressure Sore Risk was 16A score of 16 or less required prevention strategiesNo prevention strategies were listedThe skin assessment was completed and reviewed by the medication aide (MA).  Review of Resident #1's record revealed: -There was a Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report documented bilateral heel wounds with orders for heel protectors and wound care provided weeklyThere was a Hospice IDG Comprehensive Assessment and Plan of Care Update Report	

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 24 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/0	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDENT TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 269	pelvis and supports one is sitting) and a requiring wound ca -There was an order barrier cream to be needed for each incare to the left heel dressing and apply daily to prevent bre -There was an order care to the left ischemediated for the mark burns) and bordere and as needed (PR becomes soiled.  Review of the facility Assignment Plan for -The resident "has -The sheet did not solocation of the wound needed.  Interview on 03/30/2 and Wellness Coor -Hospice performed bilateral heels and wound on her butto -She thought the neopen area, and was -They had received 03/22/22 to apply b area daily.	is the weight of the body when a stage II to the sacrum are 2 times per week. For dated 03/22/22 for zinc applied to the sacrum daily as continent episode. For dated 03/31/22 for wound apply protective foam heel protectors to both feet akdown. For dated 03/31/22 for wound dial tuberosity - apply cal-grade honey-based magement of wounds and do foam dressing twice a week and the sacrum are since type of wound, and, or type of wound care  22 at 9:58am with the Health dinator (HWC) revealed: the wound care for the now the resident had a new cks. For each of the sacrum arrier cream to the sacrum	D 269			
	(HWD) on 03/30/22	lealth and Wellness Director 2 at 12:30pm revealed: ssessment for Resident #1 a MA on 02/03/22				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 25 of 86

A. BUILDING:	COMPLETED
HAL060049 B. WING	04/01/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKDALE CARRIAGE CLUB PROVIDENCE 5816 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWS ACTION SHOWS ACTION SHOWS ACTION OF THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS ACTION SHOW	HOULD BE COMPLETE
There was a facility policy that skin assessments with open area wounds should have a follow-up flow sheet completed weekly by her, that included an assessment of the wound until healed.  -She had never completed a skin assessment or weekly follow-up flow sheet for Resident #1.  -There were no other skin assessments completed by the facility since the resident started with Hospice on 01/05/22.  -Resident #1 had a heel pressure ulcer that was scabbed over, and another heel pressure ulcer that was open.  -The Hospice nurse was performing wound care twice weekly.  -If the dressing came loose or was soiled, staff would notify the Hospice nurse.  -The resident did not go to a wound clinic for evaluation and treatment.  -She was not aware of any pressure relieving interventions for Resident #1 including foam heel protectors while in bed or in the wheelchair.  -She had "something" on her buttocks, the onset of the buttocks wound was "a couple weeks ago" and she was not sure what stage it was.  -She was certain the buttocks wound was a pressure ulcer, but was not sure if it was open or just redness, and was not sure of the exact location on the resident's buttocks.  Observation on 03/30/22 at 1:25pm of Resident #1 revealed:  -She was in the living room sitting in her high back wheelchair.  -She had thick gray and pink socks and her feet were resting directly on the floor.  -She did not have her leg rests on the wheelchair and was not wearing her foam heel protectors.  Observation on 03/30/22 at 4:20pm of Resident #1 revealed:	

Division of Health Service Regulation

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
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		HAL060049	B. WING		04/0	1/2022
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				DEFICIENCY)		
D 269	Continued From pa	ge 26	D 269			
	•					
		e bed on her right side when				
	entered the room	rsonal care aide (PCA)				
		noved her incontinent brief,				
		n size loose bowel movement,				
	which had smeared	·				
		ered foam dressing over the				
		y (area right below the left				
		per thigh), the edges of the				
	dressing was soiled					
	_	ddened and had one				
		und, the size of a dime, with no				
	dressing in place, w	vith no drainage noted.				
	-The sacral area ha	nd an open wound, the size of				
	a dime, there was r	no dressing in place, and no				
	drainage noted.					
		the areas with a disposable				
		barrier cream to the sacrum				
	and left hip.					
	Interview with the s	econd shift PCA on 03/30/22				
	at 4:20pm revealed					
		ld not be removed by staff				
		ce nurse performed the wound				
	care twice weekly.	oo naroo ponomica ino maana				
	,	nly allowed to clean the				
		sable wipes and apply barrier				
	cream.					
	-The woundson Re	sident #1's buttocks, hip and				
		about 4-6 weeks ago.				
		04/00 4 0 05 6 5 6 5				
		31/22 at 9:05am of Resident				
	#1 revealed:	an un aus aittimu in la m				
		ng room sitting in her				
		te ankle socks on both feet,				
		heel protectors in place.				
	-Doin leet were fes	ting directly on the floor.				
	Observation on 03/	31/22 at 11:03am of Resident				
		the Hospice nurse visit				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 27 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IR PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDEN			
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D 269	revealed: -There was a stage ischial tuberosity th 0.1cm and had med dressing appliedThere was a stage sacrum that measured sacrum that measured 1.5c barrier cream applieThere was a stage that measured 5cm bordered foam dresThere was a scabb that measured 5cm bordered foam dresThere was a scabb that measured 1cm bordered foam dresThere was a scabb that measured 1cm bordered foam dresThere was a scabb that measured 1cm bordered foam dresThere was a scabb that measured 1cm bordered foam dresThe order for heel Hospice and should the wheelchair with skin breakdownIf a dressing becar staff should notify h CNA would apply a	ell pressure ulcer on tat measured 2.0cm x dihoney and bordered III pressure ulcer on tred 1cm x 1cm x 0.2cm applied. I pressure ulcer on the x 0.25cm, with no ded. Ded over area on the In x 2cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth asing applied. Ded over area on the rown x 1cm, with no depth as with no depth as with no depth as with a house of transfers with a house as a policies, application of both and buttocks as near the pisode, and use of the turn and position here.	1.5cm x foam  he cm, he left hip depth, eft heel with cight he	D 269			
	Review of Resident	t#1's Hospice IDG sessment and Plan of	Care				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 28 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		HAL060049	B. WING	· · · · · · · · · · · · · · · · · · ·	04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLI	IR PROVIDENCE	PROVIDENO FTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 269	Update Report note that were requested: -On 01/05/22, there history of bilateral heel protectorsOn 01/12/22, there bilateral heel woun protectors and wou-On 01/25/22, there bilateral heel woun protectors and wou-On 02/08/22, there bilateral heel woun protectors and wou-On 02/08/22, there bilateral heel woun protectors and wou a new stage II prestuberosityOn 02/22/22, there bilateral heel woun injury on the left iscare two times per -On 03/08/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On 03/22/22, there stage II pressure in tuberosity and a stawound care 2 times -On	es from 01/05/22 to 03/22/22 d from the Hospice nurse e was documentation of a neel wounds with orders for e was documentation of ds with orders for heel and care provided weekly. E was documentation of ds with orders for heel and care provided weekly. E was documentation of ds with orders for heel and care provided weekly. E was documentation of ds with orders for heel and care provided weekly, and sture ulcer on the left ischial e was documentation of ds and a new stage II pressure chial tuberosity requiring wound week. E was documentation of a njury to the left ischial age II to the sacrum requiring is per week. E was documentation of a njury on the left ischial age II to the sacrum requiring is per week.  We on 04/01/22 at 10:50am with a revealed: et the HWC know if the notify the Hospice nurse. Ectors in her room, but she is frequency for them to be	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 29 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE COM	(X3) DATE SURVEY COMPLETED			
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENO TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 269	bedShe sometimes us her lower legs wheeles wedges to reposition her even based on observation reviews it was deteinterviewable.  Attempted telephore Hospice provider of unsuccessful.  Refer to interview with 3:55pm and 04/01/22 at 10:55 pm on	sed a pillow under the she was in a wheelin the bed and underery 2 hours.  ions, interviews, and rmined Resident #1  the interview with Resident #3  with the HWC on 03/22 at 11:44am.  interview with a 2nd 50am.  with the Administrato	elchair er her legs I record was not sident #1's m was '30/22 at shift PCA	D 269			
	04/01/22 at 10:50al -The PCAs would r generated assignm would turn them int shift for reviewThe assignment sl residents' needs ar -PCAs got report at the first shift PCA ir going on with each -Second shift staff daily to discuss res care neededIf the PCAs found	make notes on their tent sheets each shi to the HWC at the eluments informed the Find care plan informat the start of each ship order to know what	computer ft and nd of each PCAs of tion. hift from t was heetings changes to wounds or				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 30 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IR PROVIDENCE 58	816 OLD	RESS, CITY, S PROVIDENCE TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 269	and/or the HWC im -The facility nurses assessments on re woundsPCAs completed s each resident in the the logs when the r  Interview with the H and 04/01/22 at 11: -The HWD was res assessment when to condition and comp documentation wee -She did not know to on the assignment regarding wounds, offload pressure an sitting in the wheeld weekly assignment -She also thought to included on the eM responsibility of the completedShe had been told foot rests were a re kept them off all wh -The facility was no care to residents.  Interview with the A 3:39pm revealed: -All staff were respo or skin breakdown -The HWC was res assessments and r -The HWC was res initial, quarterly, yea Care Plans (Persor	mediately. were responsible for sk sidents for new or open shower or bed bath log for past, but had stopped new HWC started to wor lWC on 03/30/22 at 3:544am revealed: ponsible for completing there was a change in pleted the open wounds ekly. Who generated the information booties to be applied, pleted the open wounds ekly. Who generated the information of legs where their was not included in sheets for the staff. These interventions were ARs and were the MAs to ensure the task by the HWD that wheel straint and that was white leelchair bound resident that able to provide any word dministrator on 04/01/2 consible to report new word the straint and the provide any word that the provide to report new word the straint and the provide any word that the provide any word that the provide any word that the provide to report new word the provide to report new word that the provide to report new word that the provide and the provide to report new word that the provide to report new word that the provide to report new word that the provide and the provide to report new word that the provide to report new word that the provide to report new word that the provide that the pr	ior using rk.  5pm  a skin  mation ation illow to n the  cs were lchair y she ts. bund  2 at bunds  kin tment. e nge i (PSA)	D 269			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 31 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER	S	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	IR PROVIDENCE		PROVIDEN TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 269	-Current wound information should be The daily staff assing generated by the information in the PSPThe assignment shinformation in the PSPThe assignment shinformation in the PSPThe facility failed to assistance for a resmellitus, who require on the right and left three additional opereported to the Hon and toenails on both discolored with a year to cuticle bed readsize skin tears scale whose nails needed and for a resident was care for recurrent be and 3 additional pread buttocks within #1). This failure plasubstantial risk for sineglect which consistence with G. 03/31/22 for this vicinity to the consistence with G. 03/31/22	primation and skin breal per listed on the PSA and ignment sheets were formation entered on the peets were only update PSA/PSP was updated.  In provide personal care sident with type 2 diabeted care for pressure with the peet were thick and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow, tough material catching over to the skin and pellow to the residents at a serious physical harm at the last 7 weeks (Residued the residents at a serious physical harm at titutes a Type A1 Violated a Plan of Protection in S. 131D-34 received on	d PSP.  ne PSA  d when  tes  rounds and sician, aked on and dime as eent #3), uired alcers acrum ident and ion.	D 269	BEI IGILINGT)		
D 273		. ,		D 273			
	10A NCAC 13F .09	uz nealin Care					

6899

Division of Health Service Regulation STATE FORM

0P9N11 If continuation sheet 32 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/0	01/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN			
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D 273	Continued From pa	age 32	D 273			
	to meet the routine of residents.	Il assure referral and follow-up and acute health care needs				
	This Rule is not me TYPE A2 VIOLATION	et as evidenced by: ON				
	Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (Residents #3 and #5) related to failure to contact the physician for a resident with a diagnosis of diabetes, and had wounds on his backside, an order for a urine sample to rule out sepsis, and needed a podiatrist appointment for yellowing toenails with buildup around the cuticles and skin peeling on the toes of both feet (Resident #3), and failure to contact the physician for a refill prescription for a pain medication (Resident #5).					
	The findings are:					
	Review of Resident #3's current FL2 dated 03/04/22 revealed:     Diagnoses included vascular dementia, Type II diabetes, left sided hemiplegia and glaucoma.     He was non-ambulatory and dependent on staff with the use of a wheelchair.					
	01/31/22 revealed: -Resident #3 required dressing and groom showersHe ambulated in a assistance of staff community activitie of a lift and 2 personal staff and 2 personal sta	t #3's current Care Plan dated red staff assistance for all ning needs, and for weekly wheelchair with the to the dining area and s, and transferred with the aid on assistance. y's clinical guidelines regarding				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER	Ş	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE		PROVIDENCE TE, NC 282	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page 33 skin breakdown dated September 2018 revealed:		weeled	D 273			
	-Community associ concerns to the Her (HWD)Complete docume should be in the res-Notification was to family member and (PCP).	ates should report skir alth and Wellness Dire ntation of the skin brea	n ctor akdown asible der				
	03/21/22 through 0-The Shift Assignm binder in the comm tasks for first, seconaides (MAs) and permere updated week-The Plans also list and the staff were the personal care. The tasks listed for second shift include and at bedtime, assist to diagnosis of diable while eating, he warequired 2 person a lift.	4/01/22 revealed: ent Plans were located on living room and ide nd and third shift medic ersonal care aides (PC/	in a ntified cation As), and esident, caring ent. nd er meals ake due choke nt and using a				
	3:30pm revealed: -Resident had beer wheelchair by staffRemoving the resinals of both feet we-On the left foot the dime size skin tears-The toenails on bo	dent's footwear, the to	n his es and veral ch toe.				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 34 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/0	1/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OLI	DRESS, CITY, S DPROVIDENG TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 273	areas near the cutication. On the second toe yellow, tough mater reaching over to the control there was a smaller tough material arout. The toenails on the of the left foot need. Review of Resident (HHN) documentation. The right and left to the right and left to the right foot seconail needed to be tropically to the second of the second	cles. of the left foot there was a rial caked on the cuticle bed e skin. and fifth toes of both feet amount of the same yellow and the nail beds. e second, fourth and fifth toe ed to be trimmed.  ##3's Home Health Nurse on dated 02/18/22 revealed: benails were yellow. and toe was bruised and the immed.  ##med.  ### was bruised and the immed.  ### was truined and the immed.  ### are ferral was truined and the immed.  #### was truined and the immed and immed and immed and immediately and				

6899

Division of Health Service Regulation STATE FORM

0P9N11 If continuation sheet 35 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING:		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/0	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 58	REET ADDRESS, CI 16 OLD PROVID HARLOTTE, NC	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Interview with Resid (PCP) on 03/31/22 -She was not aware abrasions, toenail on the toes of the rishe was not aware surrounding the cut feetShe relied on the she breakdown and to sher next visit to ass-Since Resident #3 aware of the condit she would have refigot care.  Interview with the HCoordinator (HWC) revealed: -She had complete assessment on 02/-She documented hishe would paround the she expected the inform her of any she providing personal lif she had been aware she was not aware breakdown on the top to she was not aware breakdown on	dent #3's primary care p at 10:00am revealed: e of Resident #3's skin liscoloration and peeling ght and left foot. e of the tough crusted m icles on several toes on staff to inform her of any schedule an appointment ess. had diabetes, had she lid ion of his toenails and toerred him to a podiatrist lealth and Wellness on 03/30/22 at 3:55pm d Resident #3's skin 17/22. his skin was dry and flak we the yellow toenails or cuticles. personal care aides (PC kin breakdown when the	y. the As) to y were his d a ector kin al Care			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 36 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLI	DDRESS, CITY, S D PROVIDENC TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 273	the cuticles of seve -The PCAs or medi have reported this of self and a podiatry made.  Interview with the A 3:39pm revealed: -She relied on the r clinical needs of the -She was not aware #3's toenail and ski -The HWD was res the SCU and could Review of the facilit from 02/18/22 throw was no documentar by a podiatrist for th toenails.  Review of Resident was no additional d notes, no entries or records (eMARs), or regarding the reside toenails by the facil b. Review of Resident was no additional d notes, no entries or records (eMARs), or regarding the reside toenails by the facil b. Review of Resides summary dated 03/ -Resident #3 was s Department (ED) for left heel pressure u -The diabetic ulcers evidence of infection	ral toes on both feet. cation aides (MAs) should condition to the HWC or her appointment should have beer  dministrator on 04/01/22 at  nursing staff to manage the e residents. e of the condition of Resident in tears on his toes. ponsible for the oversight of delegate tasks to the HWC.  by's electronic progress notes ugh 03/30/22 revealed there tion that Resident #3 was seen the care of his toes and  a #3's record revealed there ocumentation in the progress in the electronic medication or personal care records ent's skin status on his feet or ity staff.  ent #3's hospital discharge 14/22 revealed: ent to the Emergency or a possible infection of his licer. es were found to be without		DEFICIENCY)		
		with the resident's special ner history was attempted				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 37 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDENO TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
D 273	-It was unclear if ar be pursued at this to the resident was owith an order to conhours.  Review of Resident follow-up summary -On 03/14/22, Resident the hospital was urine was orderedThe hospital staff a #3's facility by phoro 03/21/22 and 03/22 to be obtained and person in the SCUOn 03/22/22, a certacility with the requirality with the requirality with the requirality with the requirality with the F. Coordinator (HWC) revealed: -She had never reconspital team that Frepeat urineShe did not have a facility by phone.  Interview with the Frevealed: -She did not receive regarding a repeat.	y further work up needed to	D 273			

Division of Health Service Regulation

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			E CONSTRUCTION		E SURVEY PLETED
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENG			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 273	-It was very difficult telephoneThe phone was co to be located on the located on the local hospital regardos/14/22 -She had never recolocal hospital regardos/14/22 -She did not have a difficult time reaching the local hospital regardos/14/22 -She did not have a difficult time reaching the local hospital regardos/1:55am was unsured local hospital family in the local hospital hosp	to contact the facility rolless and often was e unit.  Idministrator on 04/0 eived a certified letter ding Resident #3's E any reports individualing the facility by phore interview with Resmember on 03/30/22 ccessful.  Identify a contact of the facility of the facility by phore interviews, and remined Resident #1 of the facility by the facility by phore interviews, and remined Resident #1 of the facility of the	s not able  1/22 at  er from the D visit on s had a ne.  ident #3's at  record was not  /22 at  bedroom wheelchair bowel e were 2 on his f his ne depth, area over groan and	D 273			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 39 of 86

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL060049	B. WING		04/01	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDEN			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
D 273	Continued From pa	ge 39	D 273			
	03/31/22 at 10:00ar -She had ordered H Resident #3's left h -She had been info facility would chang #3's left heel wound was a new wound o -She had not been open areas on the r areasThe HWC was the facilityShe expected the	m revealed: HHN to evaluate and treat eel wounds on 02/17/22. rmed by the HWC that the le HH agencies since Resident d was not healing and there				
	revealed: -She would expect any skin breakdown care of the resident -She did not perform Resident #3 since in HHNShe expected the assessments on Reany new woundsShe was not inform break down in Resident with the A 3:39pm revealed: -She relied on the relimical needs of the -She would expect nurses if there was residentsThe HWC was the and the PCP, and we resident would expect and the PCP.	m any skin assessments on the was being followed by the HHN to perform skin esident #3 and inform her of the med of any additional skin dent #3's sacral area.  Indicate the manage the sacra and the s				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 40 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OL	ADDRESS, CITY, S .D PROVIDENO DTTE, NC 282	CE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	healthThe HWC or HWD new orders and car medication aides to performed by them  Attempted telephor 04/01/22 at 10:20al  Attempted telephor responsible family i 11:55am was unsue Based on observati reviews it was dete interviewable.  2. Review of Reside 03/04/22 revealed: -Diagnoses include spasms, and cereb -There was an orde medication used to tablet daily.  Review of Resident provider's (PCP) or 02/25/22 revealed at 1 tablet daily for pa  Observation of the at 8:57am revealed Mobic 15mg availat administration.  Observation of Res available for admin 8:57am revealed the	o was responsible to enter all re tasks into the eMAR for the overify and ensure they were selves or the PCAs.  The interview with the HWD on m was unsuccessful.  The interview with Resident #3's member on 03/30/22 at accessful.  The interviews, and record remined Resident #1 was not ent #5's current FL2 dated do vascular dementia, muscle rovascular accident (CVA). For Mobic 15mg (at reat moderate pain) take one at #5's signed primary care der summary report dated an order for Mobic 15mg take				

Division of Health Service Regulation

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/01/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BBOOK	DALE CARRIAGE CLU	IR DROVIDENCE 5816 OLD	PROVIDEN	CE ROAD		
BROOKL	DALE CARRIAGE CLO	CHARLO1	TE, NC 282	26		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 41	D 273			
	medication aide (MShe had reordered yesterday from the -The medications widay they were ordered -If the medication dissipation of the medication of the back-up pharm -The back-up pharm -The schief complain was noted as acuted -The assessment apain, related to a faroniagnoses included disease of the lumburs of the prescription for the schief complain was noted as acuted -The assessment apain, related to a faroniagnoses included disease of the lumburs of the prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription for the schief complain was noted as acuted -The prescription -The presc	Resident #5's Mobic 15mg facility's contracted pharmacy. Were delivered at night on the red or the following day. It is not come in today, he would macy had not been contacted.  If #5's PCP's progress note ealed: It was leg pain and visit type				
	medication administrevealed: -There was an entradaily for pain, scheen-Mobic 15mg was conditionally administered at 8:003/16/22 to 03/19/23/28/22 and 03/29/2-The reason the medical was documented as required for 03/11/03/19/22, 03/22/2203/29/22Mobic 15mg was conditionally at 8:00am on 03/13	locumented as not 0am on 03/11/22, 03/12/22, 2, 03/22/22 to 03/26/22,				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 42 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			E CONSTRUCTION		E SURVEY PLETED
				7 t. BOILBING.			
		HAL060049		B. WING		04/	01/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	IR PROVIDENCE		PROVIDEN TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pa	nge 42		D 273			
	medication was not available on the cart.						
	Interview with the Health and Wellness Coordinator (HWC) on 03/30/22 at 10:21am revealed: -She was not aware that Mobic 15mg was not available for administration for Resident #5 during the medication pass on 03/29/22She was not aware until she contacted the pharmacy by telephone on 03/30/22 that Residen: #6's Mobic 15mg, for a quantity of 9 tablets was last filled on 02/27/22.						
	dispensed because	quantity 9 tablets only e the facility was gettin t on cycle fill, and they	g ready				
	trying to get all med of the month. -Cycle fill had starte	dications filled on the seed in the facility in Feb	same day				
	pharmacy, and she	veral requests for refil would look for the	ls to the				
	documentation.  -The pharmacy noted medications had been dispensed for Resident #5, when they had not.  -She notified the PCP and pharmacy on 03/30/22 by telephone of the need for a new prescription for Resident #5's Mobic 15mg.						
	Interview on 03/30/ revealed:	22 at 11:15am with the	е МА				
	received yet.	or Resident #5 had no					
	-She called the pha to request a refill.	armacy again today (03	3/30/22)				
	Resident #5 reveal -A refill request for pharmacy on 03/14	Mobic 15mg was faxe	d to the				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 43 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OL	ADDRESS, CITY, S  D PROVIDENCE  OTTE, NC 282	CE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
D 273	notification of the P Interview with the H (HWD) on 03/30/22 -The MAs requeste a piece of paper an each day, or refills of the resident day, or refills of the resident day.  If there was a probomedications she existed the HWCIf the MAs contactoregarding a refill it to progress notes, and notify the HWCShe was not award 15mg was not avail 03/11/22.  Telephone interview from the facility's conditional of the day of the medical being available for the resident took generalized musculf the resident was	CP.  lealth and Wellness Director at 12:30pm revealed: d refills by placing a sticker or d faxing it to the pharmacy could be requested online. It is pected them to notify her and end the pharmacy or PCP would be documented in the did they would be expected to enter the pharmacy or expected to enter the pharmacy technician on tracted pharmacy on a revealed: lispensed on 01/21/22 for a ts, and on 02/27/22				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 44 of 86

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDENCE TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 273	increased painIt would be hard to pain because the rethe time.  Interview on 04/01/2 revealed she did not the PCP being notif prescription for Mobility of the PCP being notification of the PCPs of any issues.  The facility failed to resident with a diagopen areas on the reformation aurine sample to podiatrist appointment buildup around the the toes of both fee contact the physicial medication used to disease of the lumb administered for 19 failure placed the resident with a placed the residen	tell if he was having more esident was non-verbal most of 22 at 11:44am with HWC of have any documentation of ied Resident #5 needed a new pic 15mg until 03/29/22.  Idministrator on 04/01/22 at ponsible to handle all orders of the facility's contracted PCPs dical providers.  HWD or HWC to notify the swith medications.  Contact the physician for a nosis of diabetes who had residents backside, an order or rule out sepsis, and a pent for yellowing toenails with cuticles and skin peeling on to tell (Resident #3), and failure to the factor of a prescription for a pain treat degenerative discours spine, that was not days (Resident #5). This pesidents at a substantial risk harm and neglect which	D 273			
	accordance with G. this violation.	d a plan of protection in S. 131D-34 on 03/31/22 for TE FOR THE TYPE A2				

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1	
BROOK	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 45	D 273			
	VIOLATION SHALL	NOT EXCEED MAY 1, 2022.				
D 276	10A NCAC 13F .09	02(c)(3-4) Health Care	D 276			
	following in the resi (3) written procedur a physician or other and (4) implementation orders specified in S Rule.  This Rule is not me TYPE B VIOLATION  Based on observati reviews, the facility orders were implem residents (Resident	assure documentation of the dent's record: res, treatments or orders from r licensed health professional; of procedures, treatments or Subparagraph (c)(3) of this et as evidenced by: N ons, interviews, and record failed to ensure physician nented for 2 of 3 sampled is #1 and #3) who had orders booties to be applied to each				
	The findings are:					
	03/04/22 revealed: -Diagnoses include diabetes, left sided -The resident was cambulatory in a who Review of Resident 01/31/22 revealed:	ent #3's current FL2 dated d vascular dementia Type II hemiplegia and glaucoma. documented as non eelchair, and disoriented.  #3's current Care Plan dated ed staff assistance for all				
	dressing and groom showers.	wheelchair with the				

6899

Division of Health Service Regulation STATE FORM

0P9N11 If continuation sheet 46 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IR PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENG			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 276	assistance of staff community activitie of a lift and 2 persormunity and treat the residence of the lift with the staff daily who will be staff daily who	to the dining area and s, and transferred with n assistance.  #3's primary care prove dated 02/18/22 reversor skilled nursing to ent's open wound on the #3's Home Health Nursing dated 02/23/22 reversor heel protector to be nen out of bed, and a partiting in the wheelchard the heel wounds.  #3's HHN documentate and an order for foan the wound when his foound.  Assignment Plans from 4/01/22 revealed: ent Plans were located on living room and ide and third shift mediated and third shift mediated and the tasks for each of the	vider's aled valuate e left  rsing ealed e applied illow air to  tion foot t  in a ntified cation As). resident, pinder in h  lcers on be	D 276			
	and at 12:10pm rev -Resident #3 was s		eelchair				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 47 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDENCE FTE, NC 2822			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 276	-His legs were deporesting on the floorHe had yellow nonResident #3 was taStaff propelled him hall with his feet draThere were no foo wheelchairResident #3 was in the back table in hisHe had yellow non his feet were restimatedThere were no obsthat Resident #3 has feet for protection of the same o	endent and his feet were skid socks on both feet. aken to his room before lunch. in the wheelchair down the agging on the floor. It pedals applied to the in the dining room for lunch at swheelchair. skid socks on both feet and g on the floor. servations during these times and foam foot booties on his of his wounds. sident #3 on 03/29/22 at in wheeled to his room in his wounds and his wounds wheeled to his room in his wounds are the dalong the floor as he was hall. In a chair at the foot of the bed, in booties.  It #3's February 2022 electronic ealed there was a physician's valuate and treat an open ent's left heel.  It #3's March 2022 electronic stration record (eMAR) no entry for foam booties to en the resident was in the	D 276			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENCE TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 276	#3's primary care p wound on his left he- The start of care w days a week.  -A left heel protector applied by the staff offload the pressure wheelchair.  -After 3 weeks the secondated offload to or pillow to offload to result with no or pillow to offload to result with the left heel was shallow and redder or deeper tissue exfoul odor, mostly established wear heel was shallow and redder or deeper tissue exfoul odor, mostly established wear heel boot.  Telephone interview HHN on 03/30/22 aron 03/17/22, the helf heel and right help with the shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was shallow and redder or deeper tissue exfoul odor, mostly established was	rovider (PCP) to evalued.  yas on 02/18/22, to be or was ordered and we and a pillow under he when sitting in the wound was still unstantial when she visited the lent #3 was sitting in protective booties on the pressure on his health wound clinical frequired wound with no deposed), with redness schar, and required ective treatment and underlined to the stantial please elevated when it is while out of bed".  If we wound orders from the progress note and the wound orders from the progress note and foam booties were not on the wood orders when it is booties were not on the wood orders were not on t	e seen 2  yas to be his feet to ageable, facility to his his feet heels.  hotes  le cond tissue).  ulcer, (a ead tissue and a healing. ff, "strict sitting second ent #3's  m the hid were not e to be on isited the	D 276			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 49 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S D PROVIDENCE TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 276	D 276 Continued From page 49  Review of Resident #3's HHN progress note					
	dated 03/27/22 reversions print reminding care	ealed there was a note in large egivers to elevate the legs ep the heel boots on when the				
	Review of Resident #3's wound clinic instructions on 03/17/22 and 03/24/22 revealed: -There was an order at the initial wound clinic visit to wear foam booties dailyOn the follow up visit here was an order to off load the pressure on the heels to optimize healing, wear foam crates for lower extremities and heels.					
	on 03/30/22 at 10:3 -The assessment p edema in the woun- resident's legs whe apply santyl daily (a remove dead skin i at all times with foa the wheelchair with pillow to reduce pre -If he was in the wh and/or not applying	dent #3's wound clinic nurse to am revealed: lan was as follows: control the darea by elevating the never possible out of bed; and a product used to break up and n a wound); padding the heels m booties and when he was in his legs dependent, use a ressure on the heel wounds. The legs dependent foot booties to both feet for all dimpede the healing process				
	aide (MA) on 03/31 -Resident #3 had w heel that started ab -The wound started the left heelThe foam booties whis room were never	w with an agency medication /22 at 9:20am revealed: rounds on his right and left out a month ago. I as a dime size opening on which were ordered and left in er on Resident #3's feet when it. She had to apply the foam				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 50 of 86

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
BROOKE	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN			
	OUR MAD DV OTA		TTE, NC 282		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
D 276	Continued From pa	ge 50	D 276			
	bootiesShe had not been (03/09/22).	back to the facility since then				
	(PCP) on 03/31/22 -She had ordered F Resident #3's left h -She had been info facility would chang #3's left heel wound was a new wound o -She did not know h his heel wounds an under his feet wher pressure in the wou wound clinic on 03/ physician's summa -She expected the	ne had foam booties to protect d he was to have a pillow n in his wheelchair to prevent and area, until he went to the 17/22 and she read the ry note. staff to apply the foam booties pillow under his feet as				
	revealed: -She was responsite the residents in the -She was first awar wound last month verside to off load the pressistingShe did not know versident wounds, booties to pressure and eleval wheelchair were not assignment sheets.	e of Resident #3's left heel when a PCA reported it to her. It #3 should have foot booties he was out of bed and a pillow sure under his feet when who generated the information sheets and why Resident #3's be applied, pillow to off load tion of legs when sitting in the it included in the weekly for the staff. hese interventions were				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 51 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/0	1/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	IB PROVIDENCE 5816 OLD	PROVIDENCE TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 276	Interview with the A 3:39pm revealed: -She relied on the relinical needs of the She did not know sorders of the HHN at Attempted telephonout/01/22 at 10:20ar Attempted telephonous responsible family responsible family responsible family reviews it was deterinterviewable.  Refer to interview was 3:55pm and 04/01/22 at 3:39pm and 04/01/22 at 3:39pm and 04/01/22 at 3:39pm and 04/01/21 revealed ourspecified dementations.  Review of Resident There was a Hosp (IDG) Comprehens Care Update Report documented bilater heel protectors and	MAs to ensure the tasks were dministrator on 04/01/22 at nursing staff to manage the eresidents. Staff were not following the and the wound clinic physician, we interview with the HWD on mass unsuccessful.  The interview with Resident #3's member on 03/30/22 at cessful.  The interviews, and record rmined Resident #1 was not with the HWC on 03/30/22 at 22 at 11:44am.  The interview with a second shift is 10:50am.  The interview with a second shift is 10:50am.	D 276			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 52 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IR PROVIDENCE 5816 OLI	DDRESS, CITY, S D PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	care to left heel - ap and apply heel prot prevent breakdown  Review of Resident 12/30/21 revealed: -She had stage 2 p that were being treat Health agencyShe was a 2 perso -She was encourag in bed and to wear -She was mainly no anticipate her need	pply protective foam dressing ectors to both feet daily to	D 276			
	revealed: -She had been tran services to Hospice continued wound ca ulcers, decline, and	sferred from home health e care on 01/05/22 for are to bilateral heel pressure I weight loss. cransfers and wound care for				
	Assignment Plan for The resident "has a location of wound."  The sheet did not it location of wound.	ry's computer-generated or Resident #1 revealed: a wound". specify what type of wound or instruct the staff to use foam eg rests on the wheelchair.				
	revealed: -There was a facility with open wounds a sheet completed we	o on 03/30/22 at 12:40pm y policy that skin assessments should have a follow up flow eekly by the HWC that ment of the wound until				

Division of Health Service Regulation STATE FORM

ATE FORM 6899 0P9N11 If continuation sheet 53 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENTIE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 276	with a pillow when so the orders were enough on the MA to comple on the MA to complete on th	k to apply the foam are the feet were offlishe was in bed. Intered in the eMAR, ete the task.  30/22 at 1:25pm of fing room sitting in he and pink socks and yon the floor. In the floor of the ankle socks on be rotectors in place. It is a fing directly on the floor of the Hospice nurse of the Hospice nurse of the doam dressing applied over wound on the floam dressing applied to the	so it fell Resident r high I her feet otectors. Resident r oth feet, oor. Resident visit he left blied. he right blied. 12:00pm aled the	D 276	DEFICIENCY		
	Hospice and should	ctors was generated the worn while in the leg rests in place to	e bed or in				
	on 03/31/22 at 1:35	rst shift medication a pm revealed care pool ed application of foal eet.	rovided to				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 54 of 86

	OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		` '	E CONSTRUCTION		E SURVEY PLETED
		HAL060049		B. WING		04/	01/2022
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1	
BBOOKI	DALE CARRIAGE CLU	IR PROVIDENCE	5816 OLD	PROVIDEN	CE ROAD		
BROOK	TALL GARRIAGE GLO	DI ROVIDENCE	CHARLOT	TE, NC 282			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From pa	ge 54		D 276			
	(PCA) on 3/29/22 a -She had not been the needs of the res (SCU)The staff received beginning of the shi reportIf staff had any que MA on the floor.  Telephone interview a second shift PCA -Resident #1 had he she was not sure of applied and remove -She took them off	trained by the facility residents in a Special Co an assignment sheet ift and the previous sheet in a street in a street in and the previous sheet in a street in	regarding are Unit at the hift gave to the Dam with com, but m to be on when				
		ons, interviews, and r rmined Resident #1 w					
		e interview with Resid n 03/30/22 at 4:02pm					
	Refer to interview w 3:55pm and 04/01/2	vith the HWC on 03/30 22 at 11:44am.	)/22 at				
	Refer to telephone on 04/01/22 at 10:5	interview with a 2nd s 0am.	hift PCA				
	Refer to interview w 04/01/22 at 3:39pm	vith the Administrator o	on				
	Interview with the H	WC on 03/30/22 at 3	 55pm				

Division of Health Service Regulation STATE FORM

6899 OP9N11 If continuation sheet 55 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		HAL060049	B. WING		04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLI	IR PROVIDENCE	PROVIDENO FTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 276	and 04/01/22 at 11: -She was responsil physicians and entithe eMAR for accurissues and referral physicians for the result on the assignment wound information, pillow to offload prewhen sitting in the weekly assignment wound information, pillow to offload prewhen sitting in the weekly assignment included on the eM responsibility of the completedShe had been told foot rests were a rekept them off all whom the empty of the completedShe had been told foot rests were a rekept them off all whom the empty of the completedThe PCAs would regenerated assignment signerated assignment signe	classification of the example of the staff.  Alternative of the example of the example of the existence of t	D 276			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 56 of 86

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 276	(PSP)The daily staff ass generated by the in PSA/PSPThe assignment s	ignment sheets were iformation entered on the heets were only updated when PSA/PSP was updated.	D 276			
	implemented for 2 (Residents #3 and who had orders for applied to each foo these would imped wounds. This failur	o ensure physician orders were of 3 sampled residents #1) with bilateral heel wounds, foam protective booties to be at, and failure to implement e the healing process of the e was detrimental to the welfare of the residents and B Violation.				
	accordance with G 03/31/22 for this vio THE CORRECTIO	d a Plan of Protection in .S. 131D-34 received on blation.  N DATE FOR THE TYPE B L NOT EXCEED MAY 16,				
D 358	(a) An adult care he preparation and ad prescription and no by staff are in acco (1) orders by a lice	004 Medication Administration nome shall assure that the ministration of medications, on-prescription, and treatments	D 358			

Division of Health Service Regulation STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		HAL060049		B. WING		04/0	01/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	UB PROVIDENCE		PROVIDEN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	(2) rules in this Se	age 57 ction and the facility's	s policies	D 358			
	and procedures.	his Rule is not met as evidenced by:					
	TYPE B VIOLATION						
	reviews, the facility medications as ord (Resident #5 and # medication pass re available for admin	ions, interviews, and failed to administer lered for 2 of 3 reside (6) observed during the lated to a pain medicular and correct dose of an arms.	ents ne cation not				
	The findings are:						
	by the observation	or rate was 7% as evor and of 28 or of					
	Review of the facility's medication policy revealed medication administration shall be provided as prescribed by the resident's physician/healthcare provider.		ded as				
	03/29/22 at 8:57am	he medication pass on revealed Resident #available on the medition.	‡5 did not				
	available for admin 8:57am revealed th	sident #5's medication istration on 03/29/22 here was no Mobic 15 istration on the medic	at 5mg				
	Interview with the n 03/29/22 at 9:00am	nedication aide (MA) n revealed:	on				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 58 of 86

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		' '	E CONSTRUCTION		SURVEY PLETED
		HAL060049		B. WING		04/0	01/2022
NAME OF PROVIDER OF	R SUPPLIER				STATE, ZIP CODE		
BROOKDALE CARE	RIAGE CLU	IR PROVIDENCE		PROVIDEN TTE, NC 282			
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Mobic 15 contracte -The med day they v -If the me miss the c -She did i the medic Review or 03/04/22 -Diagnose spasms, s -There wa medicatio tablet by i  Review or provider's 02/25/22 1 tablet d  Review or dated 11/ -His chief was notec -The asse pain, relar -Diagnose disease or unspecific -The pres initiated a  Review or medicatio revealed: -There was	requested mg on 03/d pharma lications was were ordered in the contact of the companion of t	d a refill for Resident #28/22 from the facility's cy. Were delivered at night or red or the following day id not come in today, heat the back-up pharmach #5's current FL2 dated d vascular dementia, rovascular accident (Cor for Mobic 15mg (a treat moderate pain) to the fact of the form of the	on the y. ne would by for d muscle by for ake one are ated ng take note t type back live disc pain, as pain.	D 358	DEFICIENT		

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 59 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OL	DDRESS, CITY, S D PROVIDEN DTTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	-Mobic 15mg was cadministered at 8:0 03/16/22 to 03/19/2 3/28/22 and 03/29/2 -The reason the me was documented at required" for 03/11/03/19/22, 03/22/22 03/29/22 -Mobic 15mg was cat 8:00am on 03/13 03/20/22, 03/21/22, the medication was Interview on 03/30/2 and Wellness Coor-Resident #5's Mobic facility on 02/27/22, -The reason Mobic tablets was dispensive was getting ready to trying to get all medication of the month.  -Cycle fill had starte 2022.  -The pharmacy not dispensed for Resident at the country of the Mas faxed sepharmacy, and she documentation.  -She would notify the (03/30/22) by telephorescription for Resident award available for admining linterview on 03/30/2 revealed:	documented as not 0am on 03/11/22, 03/12/22, 22, 03/22/22 to 03/26/22, 22. edication was not administered is "16 - pharmacy action 22, 03/12/22, 03/16/22 to to 03/26/22, 3/28/22 and documented as administered is 22, 03/14/22, 03/15/22, and 03/27/22, even though is not available on the cart.  22 at 10:21am with the Health dinator (HWC) revealed: ic 15mg was dispensed to the for a quantity of 9 tablets. 15mg for a quantity of 9 sed was because the facility of start cycle fill, and they were dications filled on the same dated in the facility in February ed medications had been dent #5, when it had not. veral requests for refills to the	y			

Division of Health Service Regulation STATE FORM

1 6899 0P9N11 If continuation sheet 60 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			(3) DATE SURVEY COMPLETED	
		HAL060049	B. WING	B. WING		
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S'D PROVIDENC TTE, NC 2822	E ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	-She called the pha a refill.  Interview with the H (HWD) on 03/30/22 -The MAs requeste a piece of paper an each day, or refills of the HWCIf there was a probomedications she extended the HWCIf the MAs contactor regarding a refill it to progress notes, and notify the HWCShe was not award 15mg was not award 15mg was not available Resident #5 revealed -A refill request for pharmacy on 03/14 -There were no oth Review of Resident notes revealed them the PCP or the phabeing unavailable for a refill.  Telephone interview pharmacy technicia	lealth and Wellness Director at 12:30pm revealed: d refills by placing a sticker on d faxing it to the pharmacy could be requested online. Deem with getting the spected them to notify her and ed the pharmacy or PCP would be documented in the d they would be expected to they would be expected to e that Resident #5's Mobic lable for administration.  Attion refill request sheet for ed:  Mobic 15mg was faxed to the 1/22 at 4:22pm.  For faxed refill requests found.  Att #5's March 2022 progress re was no documentation with rmacy related to Mobic 15mg or administration or the need.  W on 03/31/22 at 8:39am with a sin from the facility's contracted.				
	quantity of 30 table quantity of 9 tablets -A new prescription from the PCP and v -Mobic 15mg was of	dispensed on 01/21/22 for a ts, and on 02/27/22 for a				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 61 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER  DALE CARRIAGE CLU	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENCE FTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	begin on 04/07/22.  Telephone interview Resident #5's primarevealed: -She was aware of by the facilityThe resident took is generalized muscul-if the resident was days, it would be poincreased painIt would be hard to pain because the rethe time.  Attempted telephor responsible party ounsuccessful.  Telephone interview a second shift persident #5 had is pain medication at the notified the me having painHe only complaine transferring from the she could tell by he that the pain was be interview on 04/01/2 and Wellness Coordid not have any donotified Resident #8 for Mobic 15mg untattention on 03/29/20.  Refer to interview well.	or on 03/31/22 at 10:2 ary care provider (PC) a refill request made Mobic 15mg daily for loskeletal pain. Without the medicationsible for him to have tell if he was having esident was non-verbase interview with Resin 03/31/22 at 11:00a on 04/01/22 at 10:5 onal care aide (PCA) ow back pain and refit times. dication aide (MA) if d of pain when he was bed to the wheelch is grimacing facial exact at times.  22 at 11:44am with the dinator (HWC) reveal occumentation of the Forequired a new presidit was brought to he	this week on for 19 re more relal most of ident #5's m was on with revealed: used his he was as air. corression he Health led she PCP being scription er				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 62 of 86

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
BROOKE	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDEN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ITE, NC 282	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
D 358	Continued From page 62		D 358			
	Refer to interview v 04/01/22 at 3:39pm	vith the Administrator on i.				
	03/29/22 at 9:15am -There was an oper 125mg with instruct mouth twice dailyThere were 6 caps that was dispensed -The medication aid Depakote 125mg 2 Resident #6There were 4 caps after the medication -The instructions of give Depakote 125 activity, total 500mg	n bubble card of Depakote tions to give 4 capsules by sules left on the bubble card on 03/01/22. de (MA) administered capsules at 9:15am to sules left on the bubble card n pass for Resident #6. pserved on the eMAR were to mg 4 capsules for seizure				
	-The current order administer 2 capsu -She had been adm	ninistering 2 capsules in the econd shift MA would				
	04/05/21 revealed: -Diagnoses include dementiaResident #6 was contract there was an order 125mg give 4 caps Review of Resident	t #6's current FL2 dated d seizure disorder and onstantly disoriented. er for Depakote sprinkles ules twice daily (total 500mg).				
	02/25/22 revealed a	rder Summary Report dated an order for Depakote 125mg seizure activity, total 500mg				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 63 of 86

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL060049	B. WING		04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER		<u>I</u>	STATE, ZIP CODE	04/0	71/2022
	DALE CARRIAGE CLI	5816 OLD	PROVIDEN			
BROOK	JALL CARRIAGE CE	CHARLO	TTE, NC 282	226		ı
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	Continued From pa	age 63	D 358			
	twice daily.					
	medication administrevealed: -There was an entrocapsules for seizur daily, scheduled for Depakote 125mg as administered at 03/29/22, and at 7: 03/28/22.  Observation of Resavailable for admin 12:00pm revealed: -There was 1 used 125mg with 4 caps quantity of 30 caps -There were 10 undepakote 125mg for the overstock drause of the bubb 03/25/22, and three	bubble card of Depakote ules left on the card, with a ules dispensed on 03/01/22. opened bubble cards of or a quantity 30 capsules each, awer on the medication cart. ole cards were filled on e were filled on 03/01/22. of 304 Depakote 125mg				
	from the facility's co 03/31/22 at 8:39am -Depakote 125mg a quantity of 240 ca dispensed in Febru quantity of 240 cap quantity of 240 cap -A verbal order was health (MH) PCP of 125mg take 2 caps reduction of the cur	was dispensed on 01/20/22 for apsules, no Depakote was lary 2022, 03/01/22 for a sules, and on 03/25/22 for a sules. It is received from the mental on 03/30/22 for Depakote sules twice daily, to start a				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 64 of 86

AND DUAN OF CORRECTION TO THE TOTAL NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENG			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Interview with the m 03/31/22 at 10:30ar - The MH PCP had dose of Depakote 1 twice daily (250mg twice daily) The MA never recedose of Depakote, decrease the dose - She was the only Mast week, therefore the incorrect dose.  Telephone interview care provider (PCP revealed: - She was not aware Depakote made by - The facility had noterror made on 03/2 - Resident #6 would seizure activity due medication.  Attempted telephone Power of Attorney (was unsuccessful.  Refer to interview w Coordinator (HWC)  Refer to interview w 04/01/22 at 3:39pm	ake 4 capsules twice along the dication aide (MA) in revealed: mentioned a change 25mg last week to 2 twice daily instead of twice daily instead of the experience of the order to dechowever she chose to her own. MA that spoke to the experience she was the only May with Resident #6's on 03/31/22 at 10:2 to of a recent order of the MH PCP. It notified her of the me 19/22. Thave an increased in the interview with Resident Hoad on 04/01/22 at 11:4 with the Health and Wall on 04/01/22 at 11:4 with the Administrator	in the capsules f 500mg crease the to MH PCP A to give primary 20am change for medication risk for er ident #6's 11:05am Vellness 4am.	D 358			
	revealed:	ole for the managem					

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 65 of 86

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		HAL060049	B. WING		04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CL	IR PROVIDENCE	PROVIDENO TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	MAs, PCAs and Lic (LPNs).  -She was notified by received from the iroutside provider or residents or family to process.  -She and the facility into the eMAR systems and the facility into the eMAR systems and responsive were entered on the business hours and responsive were entered on the business and carried by them resident middle and responsive was not awailable for the resident middle was not available was not ava	censed Practical Nurses' by the HWD of new orders in house PCP. orders would come in from members for her or the HWD by nurses could enter orders em along with the HWD. ble to review all orders that e eMARs after normal d on the weekends. entered into the Point Click e eMARs for the nurses and f22 at 3:39pm with the aled: sponsible to handle all orders by the facility's contracted PCPs	D 358			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 66 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/0	1/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S DPROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	Continued From pa This failure was det and welfare of Resi constitutes a Type I	rimental to the health, safety dent #5 and #6 and	D 358			
	accordance with G. this violation.  CORRECTION DA	d a plan of protection in S. 131D-34 on 03/31/22 for TE FOR THE TYPE B. NOT EXCEED MAY 16,				
D 464		7 Special Care Unit Res.	D 464			
	Profile & Care Plan In addition to the re .0801 and 13F .080 facility shall assure (1) Within 30 days of care unit and quarted develop a written reassessment data the behavioral patterns daily living skills, special abilities and cognitive impairment (2) The resident care 13F .0802 of this Stor revised based or specify programming social and health caresident attain or mediated.	quirements in Rules 13F 12 of this Subchapter, the the following: of admission to the special erly thereafter, the facility shall esident profile containing hat describes the resident's self-help abilities, level of ecial management needs, d disabilities, and degree of ht. The plan as required in Rule hubchapter shall be developed hat the resident profile and hat involves environmental, hare strategies to help the haintain the maximum level of he and compensate for lost				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				D WING				
		HAL060049		B. WING		04/0	1/2022	
NAME OF I	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE			
BROOK	DALE CARRIAGE CLI	UB PROVIDENCE		PROVIDENO TTE, NC 282				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
D 464	Continued From pa	age 67		D 464				
	TYPE B VIOLATIO	N						
	reviews, the facility Care Unit Resident completed within 30 and within 10 days in the resident's co residents (Residen pressure ulcers on (Resident #1) and to diagnosis of diabet ulcers on both feet	ions, interviews and refailed to ensure a Spat Profile and Care Plat 0 days of admission, following a significant ndition for 2 of 3 sames that and #3) with recut the heels of both feet for a second resident es mellitus with press (Resident #3).	ecial n was quarterly t change pled urrent t with a					
	The findings are:							
	01/01/22 revealed	ty's current license ef the facility was license SCU) with a capacity	ed as a					
	07/16/21 revealed	ent #1's current FL2 o diagnoses included itia without behaviors.						
		t #1's Resident Regis admitted to the SCU o						
	Profile and Care PI -She had stage 2 p that were being treat Health agencyShe was encourage bed and to wear he -She was a 2 perso -She was incontine	ent of bowel and bladd chair for mobility and	vealed: heels lome it while in es.					

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 68 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDENO TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 464	-She had a diagnos staff assistance to cliving (ADLs)She was mainly not anticipate her need -She currently used Hospice consult ware -She required limited and was totally deported Review of Resident -There was a Hosp (IDG) Comprehens Care Update Report documented bilater heel protectors and -There was a physited wound care to the If foam dressing and feet daily to prevent -The previous SCU Plan was completed -There were no quared and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021There was no sign Profile and Care Plans beto December 2021.	sis of dementia and required complete all activities of daily on-verbal and staff had to s.  I Home Health services, but a s being obtained.  I d assistance with transfers endent for all other ADLs.  I #1's record revealed: ice Interdisciplinary Group ive Assessment and Plan of t dated 01/12/22 which all heel wounds with orders for wound care provided weekly. cian's order dated 03/31/22 for eft heel - apply protective apply heel protectors to both to breakdown.  Resident Profile and Care d 05/01/21.  Interly SCU Resident Profile ween May 2021 and ifficant change SCU Resident an between January 2022 and #1's current Skin Observation				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 69 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	HAL060049	B. WING		04/	01/2022	
NAME OF PROVIDER OR SUPPLIER BROOKDALE CARRIAGE CL	UB PROVIDENCE 5816 OL	DDRESS, CITY, ST D PROVIDENC DTTE, NC 2822	E ROAD			
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
-The skin assessmereviewed by the more reviewed by the more Review of the facil Assignment Plan for the resident "has -The resident "has -The sheet did not location of wound,  Observation on 03 #1 revealed: -She was lying in the second shift perentered the roomWhen the PCA resident is a bord left is chial tuberosis extends from the besupports the weight sitting), the edges was intactThe left hip was readditional opened no dressing in place. The sacral area hed ime, there was not drainage notedThe PCA applied and left hip areas.  Observation on 03 #1's wounds during revealed: -There was a staggischial tuberosity the sacral staggischial staggischial tuberosity the sacral staggischial sta	ategies were listed. hent was completed and edication aide (MA). hity's computer-generated or Resident #1 revealed: a wound". specify what type of wound, or care to be provided. he bed on her right side when ersonal care aide (PCA) howed her brief, there was a bowel movement, which had					

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 70 of 86

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		HAL060049	B. WING		04/01/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKE	ALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 464	sacrum that measured hydrocolloid dressin -There was a stage that measured 1.50 barrier cream appli -There was a scabl that measured 5cm bordered foam drest -There was a scabl that measured 1cm bordered foam drest -There was a scabl that measured 1cm bordered foam drest -There was a scabl that measured 1cm bordered foam drest -There was a scabl that measured 1cm bordered foam drest -The order for heel Hospice and should the wheelchair with skin breakdownThe facility usually Resident #1 when stated -The facility at 3:39pm 2. Review of Resided -Diagnoses included diabetes, left sided -The resident was a wheelchair, and distributed for the was account (SCU) on 02/2	e II pressure ulcer on the gred 1cm x 1cm x 0.2cm, applied. e I pressure ulcer on the left hip cm x 0.25cm, with no depth, ed. bed over area on the left heel ax 2cm, with no depth, with ssing applied. bed over area on the right heel ax 1cm, with no depth with ssing applied. 22 at 11:03am and 12:00pm Hospice nurse revealed: protectors was generated by do be worn while in the bed or in leg rests in place to prevent what the heel protectors on she came to the facility.  With the Administrator on an ent #3's current FL2 dated and vascular dementia Type II hemiplegia and glaucoma. In a coriented.  It #'3's Resident Register dimitted to the Special Care (7/20).  It #3's Home Health Nursing	D 464			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 71 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	
HAL060049	B. WING		04/0	1/2022
NAME OF PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
BROOKDALE CARRIAGE CLUB PROVIDENCE	PROVIDENC TTE, NC 2822			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
heel protector to be applied by the staff daily when out of bed, and a pillow under his feet when sitting in the wheelchair to reduce pressure on the heel wounds.  On 03/03/22, there was an order for foam foot booties to protect the wound when his foot dragged on the ground.  Review of Resident #3's most recent Skin Observation Form dated 02/17/22 revealed: -Skin was documented as "excessive dryness and flakiness", with an open area on the left heelFriction and shearing were documented as "not a problem" -A Braden Scale was used to predict the risk of developing pressure sores in a residentResident #3's Braden Scale was 14, indicating a moderate risk for developing pressure soresA Braden Scale score of 16 or less required prevention strategiesNo prevention strategies were listedAn Open Area Flowsheet was to be completed due to the wound noted on the left heelThe form was completed by the Health and Wellness Coordinator (HWC).  Review of Resident #3's record revealed: -There was no documented SCU Resident Profile and Care Plan completed within 30 days of admission and no documented quarterly profiles thereafterThe current SCU Resident Profile and Care Plan was dated 01/31/22 -The previous SCU Resident Profile and Care Plan was dated 07/30/21.  Interview with the Health and Wellness Coordinator (HWC) on 04/01/22 at 11:45am revealed:				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 72 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/01/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE A	D BE	(X5) COMPLETE DATE
D 464	the quarterly profile -She did not know to completed on Residents and the sheets for the personsidentsThe assignment sheets for the common she did not know to on the assignment wounds, booties to load pressure was assignment sheets assignment sheets assignment sheets assignment sheets assignment sheets assignment sheets assignment sheetsShe also thought to included on the eM responsibility of the completed.  Interview with HWE revealed: -It was the respons the quarterly profile and the review recently and did not quarterly and did not quarterly profiles have a sheet as a signment sheet.  Refer to interview with the provided over and the sheet and the sheet as a signment sheet and care Plans have and Care Plans have and Care Plans have and Care Plans have a sheet as a signment sheet as a si	s. he quarterly profiles were not dent #3. staff to follow the assignment onal care needs of the neets were available in a on living area. who generated the information sheets and why Resident #3's be applied and a pillow to off not included in the weekly for the staff. hese interventions were ARs and were the MAs to ensure the tasks were on 0 on 03/30/22 at 12:40pm ibility of the HWC to complete s on the residents in the SCU. Site to the HWC in her tasks. Wed the resident's records to the task of the tas	D 464			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 73 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  C  (X3) D  C			
		HAL060049	B. WING		04/0	1/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OLD	DRESS, CITY, S PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 464	Plan (PSP) docume -Current wound find		D 464			
	Resident Profile and quarterly and within change in the residents ampled residents recurrent pressure feet, with orders for obtained 3 additions sacrum and buttock pressure to the wouresident with diabet on both feet, orders pillows to reduce the while sitting in the vaddressed (Resided detrimental to the hour purchased of the sitting in the vaddressed of the s	ensure a Special Care Unit d Care Plan was completed 10 days following a significant ent's condition for 2 of 3 (Resident #1 and #3) with ulcers on the heels of both protective booties, who all pressure ulcers on the ks, and orders to offload unds (Resident #1), and a les who had pressure ulcers for protective booties and e pressure on his wounds wheelchair, and was not the thin thin thin thin thin thin thin thin				
	accordance with G. 04/21/22 for this vic	d a Plan of Protection in S. 131D-34 received on plation.				
		NOT EXCEED MAY 16,				
D 468	Orientation And Tra		D 468			
	Orientation And Tra	-				
	The facility shall as:	sure that special care unit staff				

Division of Health Service Regulation STATE FORM

6899 0P9N11 If continuation sheet 74 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I EAR OF CONTROL	BERTH TO WISH TO WEEK	A. BUILDING:			
	HAL060049	B. WING		04/0	1/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKDALE CARRIAGE CLU	IR PROVIDENCE	PROVIDENO TTE, NC 282			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
training: (1) Prior to establis administrator shall of 20 hours of training be served for each operated. The adm plan to train other sidentifies content, to schedules regarding (2) Within the first employee assigned special care unit shorientation on the noresidents. (3) Within six montoresidents. (4) Staff responsible supervision within the unit shall specific to the poput to the training and of Rule .0501 of this Sof orientation requiresion within the supervision within the supervision within the supervision within the supervision within the six hours shall supervision within the super	following orientation and thing a special care unit, the document receipt of at least specific to the population to special care unit to be sinistrator shall have in place a taff assigned to the unit that exts, sources, evaluations and g training achievement. week of employment, each to perform duties in the all complete six hours of ature and needs of the this of employment, staff sonal care and supervision complete 20 hours of training lation being served in addition competency requirements in subchapter and the six hours ed by this Rule. le for personal care and the unit shall complete at least ing education annually, of all be dementia specific.	D 468			

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 75 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 O	ADDRESS, CITY, S LD PROVIDENO OTTE, NC 282	CE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 468	checklist, State Spereview of the docurular agency person specific forms not in The 6 hours of oried Unit (SCU) training checklist.  1. Review of Staff Apersonnel record restaff A was hired on There was no docut the required 6-Hour week of hire.  Telephone interview 4:11pm revealed: -She worked in the She had not receive from the facilityShe did not know with training at the facility any while employed She received training agency.  Refer to telephone agency Registered 10:20am.  Refer to interview with Coordinator (HWC) Refer to interview with Coordinator (HWC) Refer to was hired or Staff C was hired or Staf	ecific Agency checklist and the nents in the binder. Innel were to provide any state accluded in the checklist. Interview and included in the was not included in the second was not included in the first of which was fall and with the first was not included in the first was not included.  SCU at the facility.  Yed any SCU specific training who was responsible for SCU by since she did not receive in there.  In grow the local staffing hurse (RN) on 04/01/22 at with the Health and Wellness on 04/01/2022 at 11:45am.  With the Administrator on was needed:				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 76 of 86

Division	of Health Service Re	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDENO FTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 468	Continued From pa	ge 76	D 468			
	the required 6-Hour SCU training within the first week of hire.					
	revealed: -She usually worked 3:00pm in the facilit -She worked in the -She was not award at the facilityShe had not comp facility.  Refer to telephone agency Registered 10:20am.  Refer to interview w Coordinator (HWC)	SCU at the facility. It of any SCU training provided leted any SCU training at the leted any SCU training at the linterview with the staffing Nurse (RN) on 04/01/22 at with the Health and Wellness on 04/01/2022 at 11:45am.				
	on 04/01/22 at 10:2 provide the 6 hours training to the staff  Interview with the Harevealed: -She had been emphast 3 monthsShe was not responshe staffing agency trainingShe did not provide staff.	IWC on 04/01/22 at 11:45am ployed at the facility for the ensible for coordinating with regarding hiring of staff or eany SCU training to agency				
		ellness Director (HWD) was uring staff had completed the				

STATE FORM 6899 If continuation sheet 77 of 86 0P9N11

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/0	1/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROOKE	ALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 468	Continued From pa	ge 77	D 468			
	training to meet reg	ulatory requirements.				
D912	3:39pm revealed: -The facility's RN ed check off all agency training requirementure. She expected the staff training record for placement in period to the SCU training wincluded the 6-hour G.S. 131D-21(2) Description.	staffing agencies to provide s and credentials to the facility	D912			
	Every resident shall 2. To receive care a adequate, appropria	I have the following rights: and services which are ate, and in compliance with I state laws and rules and				
	reviews, the facility received care and s and in compliance v laws and rules and Care, Medication Ai	ons, interviews and record failed to ensure residents ervices which were adequate, with relevant federal and state regulations related to Health de Training and Competency, resident Profile and Care Plan,				
	The findings are:					
	reviews, the facility orders were implem	ations, interviews, and record failed to ensure physician nented for 2 of 3 sampled s #1 and #3) who had orders				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/0	01/2022
	ROVIDER OR SUPPLIER	IB PROVIDENCE 581	6 OLD	DRESS, CITY, S PROVIDEN TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	foot when out of beau NCAC 13F .0902(c) Violation)].  2. Based on interviet acility failed to ensure and C) who admires completed their medications. [Refer G.S. 131D-4.5B(b)   Competency (Type B. Based on observative with the resident series of the completed within 30 and within 10 days for the resident (Resident bressure ulcers on the resident #1) and for the resident #1) and for the completed within 30 and within 10 days for the resident (Resident #1) and for the resident #1) and for the completed within 30 and within 10 days for the resident #1) and for the complete wilcers on both feet (D464 10A NCAC 13 Resident Profile and Violation)].  4. Based on observative wilcers and #6 and the facility medications as order (Resident #5 and #6 and the facility of	booties to be applied to ed. [Refer to Tag D276 10/0 (3-4) Healthcare (Type ews and record reviews the tree 2 of 3 sampled staff (anistered medications had dication clinical skills ion prior to administering to Tag D935 10A NCAC Medication Aide Training B Violation)].  ations, interviews and reception and Care Plan was days of admission, qualifollowing a significant chandition for 2 of 3 sampled #1 and #3) with recurrent the heels of both feet for a second resident with the session of the second resident with the se	A B ne (Staff l 13F and cord al sas urterly ange l nt l a Fag nit ecord l cord	D912			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL060049	B. WING		04/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BROOK	DALE CARRIAGE CLU	IR PROVIDENCE	PROVIDEN TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D914	Continued From pa	ge 79	D914			
D914	G.S. 131D-21(4) De	eclaration of Residents' Rights	D914			
	Every resident shall	laration of Residents' Rights I have the following rights: ntal and physical abuse, ation.				
	reviews, the facility	s, observations and record failed to ensure all residents ect related to personal care				
	The findings are:					
	reviews, the facility personal care assis residents (Resident resident with diabet the heels of both ferprotective booties, owounds and not to during ambulation with the Home Health Niphysician and not a and nail care on bowith recurrent pressifeet, orders to place obtained 3 additional buttocks, and order wounds (#1). [Reference of the control of t	ews, observations and record failed to ensure staff provided tance to 2 of 3 sampled as #3 and #1) including one ic pressure ulcer wounds on et and orders to place off load pressure to the drag his feet along the floor were followed as ordered by urse (HHN) and wound care ttending to multiple skin tears th feet (#3), and a resident sure ulcers on the heel of both a protective booties, who all wounds on the sacrum and is to off load pressure to the real to Tag D269 10A NCAC 13F Care and Supervision (Type A1)				
	2. Based on intervie	ews, observations and record				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL060049		B. WING		04/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDEN TE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
D914	reviews, the facility personal care assis residents (Resident resident with diabet the heels of both fe protective booties, wounds and not to during ambulation with the Home Health Niphysician and not a and nail care on bowith recurrent pressent, orders to place obtained 3 addition buttocks, and order wounds (#1). [Refe. 0902(b) Health Care	failed to ensure staff provided stance to 2 of 3 sampled its #3 and #1) including one itic pressure ulcer wounds on et and orders to place off load pressure to the drag his feet along the floor were followed as ordered by urse (HHN) and wound care ittending to multiple skin tears th feet (#3), and a resident sure ulcers on the heel of both the protective booties, who all wounds on the sacrum and its to off load pressure to the ir to Tag D273 10A NCAC 13F ire (Type A2 Violation)].	D914			
D935	G.S. § 131D-4.5B (Medication Aides; Tevaluation Require  (b) Beginning Octol home is prohibited any unsupervised rethat individual has predication aide duan adult care home of the following:  (1) A five-hour train Department that individual nation aide duan adult care home of the following:  (1) A five-hour train Department that individual nation all of the following.  The key principle administration.  The federal Center of the desired that individual has predicted and the following:	b) Adult Care Home Training and Competency ments.  Der 1, 2013, an adult care from allowing staff to perform nedication aide duties unless previously worked as a ring the previous 24 months in a or successfully completed all ing program developed by the cludes training and instruction g:	D935			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/01/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BROOKI	DALE CARRIAGE CLU	JB PROVIDENCE	PROVIDEN			
0(4) ID	CHIMMA DV CTA		TTE, NC 282		DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
D935	Continued From pa	ge 81	D935			
D935	applicable, safe injeprocedures for morbleeding occurs or exists.  (2) A clinical skills of NCAC 13F .0503 a  (3) Within 60 days individual must hava. An additional 10-developed by the Ditraining and instruct. The key principle administration.  2. The federal Cent Prevention guidelin applicable, safe injeprocedures for morbleeding occurs or exists.  b. An examination of by the Division of Haccordance with surface with surface and C) who admit completed the medications.  The findings are:  1. Review of Staff A.	ection practices and hitoring or testing in which the potential for bleeding evaluation consistent with 10A and 10A NCAC 13G .0503. From the date of hire, the ecompleted the following: hour training program repartment that includes tion in all of the following: es of medication control and, if ection practices and hitoring or testing in which the potential for bleeding developed and administered realth Service Regulation in bsection (c) of this section.  The service of the section in the ection of the section in developed and administered realth service regulation in the section (c) of this section.  The service of the section in the section of the section in the section of the section in the section of the section o	D935			
	-Staff A was hired or -There was docume written MA exam or	n 12/29/21. entation she passed the				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 82 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL060049		B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	JB PROVIDENCE	5816 OLD	DRESS, CITY, S PROVIDENG TTE, NC 282			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D935	-There was docume 5/10/15 hour trainin -There was no doct the medication clini validation.  Review of a resider medication adminis revealed Staff A documedications on 01/2  Review of another revealed Staff A documedications on 8 data revealed Staff A documedications on 12 of 02/21/22.  Review of a resider revealed Staff A documedications on 12 of 02/21/22.  Review of a resider revealed Staff A documedications on 03/4  Interview with Staff revealed: -She was hired by lanuary 2022The local staffing a had the medication list completed prior facilityShe had not completed at the facilityShe did not know the staff of t	entation she complete g in 01/2022.  Jumentation Staff A corcal skills competency of the January 2022 electration record (eMAR cumented administeri 20/22.  Tresident's January 2022 electration record (eMAR cumented administeri ays from 01/04/22 to 0 of the January 2022 electration record (eMAR cumented administeri days from 01/04/22 to 0 of the January 2022 eMAR cumented administeri days from 02/01/22 to 10 of the January 2022 eMAR cumented administeri 01/22.  A on 04/01/22 at 4:11 ocal a staffing agency and started at the fact agency made sure that competency validation to allowing her to worleted any facility training who was responsible to the since she did not residue.	mpleted ctronic ) ng 22 eMAR ng 01/28/22. MAR ng o rin ility in at she on check rk at the ing since for	D935			
	Refer to interview w	vith the Health and W	ellness				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL060049	B. WING		04/	01/2022
	PROVIDER OR SUPPLIER	IB PROVIDENCE 5816 OL	DDRESS, CITY, ST D PROVIDENC DTTE, NC 2822	E ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D935	Refer to interview w 04/01/2022 at 3:39g 2. Review of Staff C personnel record re-Staff C was hired c-There was docume written MA exam or There was docume 5/10/15 hour training. There was no document the medication clinical validation.  Review of a resider medication administration administration on 7 document the medication administration of remaining the medications on 7 document the medications on 7 document the medication administration of remaining the medications on 11 document the medication of the medications on 11 document the medication of the medications on 11 document the medication of the medication	o3/30/2022 at 12:30pm.  with the Administrator on om.  C's, medication aide (MA) evealed: on 02/03/22. entation she passed the o9/26/17. entation she completed the g in 02/2022. umentation Staff C completed cal skills competency  ot's February 2022 electronic tration record (eMAR) cumented administration of ays from 02/03/22 - 02/25/22.  resident's February 2022  off C documented medications on 02/12/22.  ot's March 2022 eMAR cumented administration of days from 03/02/22 - 03/29/22  C on 04/01/22 at 10:00am  MA in the facility from a local				
	staffing agency sind -She had not comp skills competency v Nurse (RN) since s facilityShe had completed being employed at the staff of the staff	ce February 2022.  Ileted the medication clinical ralidation with a Registered he started working at the done in-service training since				

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 84 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
		HAL060049	B. WING		04/0	1/2022				
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE						
BROOKDALE CARRIAGE CLUB PROVIDENCE 5816 OLD PROVIDENCE ROAD CHARLOTTE NC. 28226										
CHARLOTTE, NC 28226  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)										
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COMPLÉTE DATE					
D935	Continued From page 84		D935							
	needed.									
		vith the Health and Wellness 03/30/2022 at 12:30pm.								
	Refer to interview v 04/01/2022 at 3:39	vith the Administrator on om.								
	Refer to Tag 358, Medication Administration, Type A2 Violation.  Interview with the HWD on 03/30/2022 at 12:30pm revealed: -The medication aide training records were emailed to her by the staffing agency, and were not currently in the personnel recordsShe would request the training records for the medication aidesThe facility had not completed a medication clinical skills competency validation for agency medication aides.									
	3:39pm revealed: -She was not aware medication compet validated by a Regi administering medi -The facility's RN E	dministrator on 04/01/2022 at e of the regulation that the ency evaluation was to be stered Nurse (RN) prior to cations in the facility. ducator was responsible to y staff on facility specific its.								
	(Staff A and C), who medications to reside the Medication Adm Check off prior to a causing one reside on 03/29/22 to receive	ensure 2 of 3 sampled staff o were administering dents in the facility completed ninistration Clinical Skills dministering medications, nt during the medication pass eive the wrong dosage of an lication. The facility's failure to								

Division of Health Service Regulation

STATE FORM 6899 0P9N11 If continuation sheet 85 of 86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED						
		HAL060049	B. WING		04/(	01/2022						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
BROOKDALE CARRIAGE CLUB PROVIDENCE  5816 OLD PROVIDENCE ROAD CHARLOTTE, NC 28226												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE						
D935	ensure medication requirements prior medications resulte detrimental to the hather resident and co.  The facility provided accordance with G. this violation.  CORRECTION DA	ge 85 aides (MAs) met training to the administration of ed in an error which was ealth, safety, and welfare of nstitutes a Type B Violation. d a plan of protection in S. 131D-34 on 04/01/22 for TE FOR THE TYPE B NOT EXCEED MAY 16,	D935									

6899